VERMONT AGENCY OF HUMAN SERVICES
DEPARTMENT OF HEALTH

CERTIFICATE OF APPROVAL APPLICATION/ PROPOSAL FOR VSH FUTURES CRISIS STABILIZATION/ INPATIENT DIVERSION BEDS COVER PAGE

Applicant: Lamoille County Mental Health CRT program

Project Title: Crisis Stabilization Bed

Principal Contact: James Berry

Address: 520 Washington Highway (street) Morrisville (town/city)

Vermont (state) 05661 (zip code) 888-4914 (telephone number)

PROJECT TYPE & AMOUNT

- ☐ Capital expenditure exceeding $1,500,000 for construction, development, purchase or long-term lease of property or existing structure
- ☐ Purchase of a technology, technology upgrade, other equipment or a renovation with a cost exceeding $1,000,000
- X The offering of a health care service having a projected annual operating expense that exceeds $500,000 for either of the next two budgeted fiscal years if the service was not offered by the health care facility within the previous three fiscal years.

A. Proposed Capital Expenditure (Total Table 1) $_____

B. Proposed Lease Amount (payment times term) $_____ I certify to the best of my knowledge and belief, that the information in this application is true and correct and that this application has been duly authorized by the governing body of the applicant.

CERTIFYING OFFICIAL: William K.Alexander CEO (Name & Title)

SIGNATURE: Wm K. Alex

DATE: 9.7.07

I. Abstract

Lamoille County Mental Health requests consideration for the funding of a two bed Crisis Stabilization/Hospital Diversion facility. Currently there are no staffed crisis beds in the Lamoille Valley. This has been an on going issue for the entire service delivery system. It has also been an issue in regards to quick access to a crisis facility. Often consumers have to wait hours and sometimes days for a bed to become available. This often results in a hospitalization as the only alternative. The presence of a two bed crisis facility will be a valuable resource to the Lamoille Valley and state wide. The Crisis Beds will be located in one of the two bed room apartments at Copley House. Copley House is a twenty unit community care facility located on Washington Highway in Morrisville Vermont. It is two hundred yards from Copley Hospital and the Out Patient facility of Lamoille County Mental Health. The apartment is configured with the bed rooms located at opposite ends of the central living area thus providing privacy and confidentiality. The apartment, as does all of Copley House, has a sprinkler system to reduce the risk in case of a fire. The staffing pattern will be two staff on duty twenty four hours a day three hundred and sixty five days a year. Either a Manager or a Registered nurse will be on duty during the morning and after noon/evening shifts. They will also share on call duties. The facility will be used to provide a safe environment for people in crisis who are at risk to harm of self or others and at risk for a psychiatric hospitalization. The facility will also be used as a step down for people in a hospital who are not stable enough to be on their own but need supports to transition into the community. In addition the facility will be used as a short term housing option in situation where a consumer has become homeless. In the event the crisis beds are not occupied the staff will be assigned out reach responsibilities to do up stream crisis prevention work with consumers identified by the CRT Case mangers. The Registered nurse will do out reach work with local physician practices to create a professional relationship which will be beneficial for referrals as well as treatment coordination.

II. Proposal Overview and Program Description

Our crisis bed program will be multi-purpose, providing community-based crisis outreach for treatment in the least restrictive environment. In facility, the crisis bed will provide an early crisis bed intervention as an alternative to hospitalization, a safe community-based alternative for observation and assessments, preventative crisis stabilization beds for people who are in transition and at high risk to become homeless and hospitalized, and as a transitional step-down crisis bed from a hospital back to the community. We are also applying for the DDCAT grant for dual diagnosis, and hope to use this to supplement training and resources for our crisis bed. The program will be contained within LCMH Emergency Services, but have its own manager. Our proposed staffing pattern is for 10 staff, including an RN, to cover 2 beds, 24/7, and daily psychiatric consult. The population served would primarily be CRT consumers, but would also include adult outpatient and the general adult population in Lamoille County as appropriate. We would utilize existing treatment providers for each person served, and explore additional resources, such as peer supports.

The proposed location is in our Copley House apartment, which will minimize building costs, and is in close proximity to Copley Hospital, ambulance, Morrisville police, and LCMH Emergency Services.

Admission Criteria and Care Management.

This crisis stabilization program will be completely voluntary and based on collaborative treatment planning between the client and their treatment team. Full disclosure and engagement in treatment will be critical factors for a client's participation in the program.

Clients currently receiving services from LCMH will become aware of this service during on-going treatment planning processes. During times of crisis, the crisis stabilization program will become an alternative treatment option for the client to consider. When clients are in a hospital, part of the discharge planning process would be to discuss the crisis stabilization program as a discharge option. Hospitals and local providers would be made aware of the crisis stabilization program through regular contacts with the hospital liaison, case manager, emergency services and crisis stabilization staff. Recognition of this service by local providers will occur through on-going collaboration and service coordination.
Our crisis bed program will be multi purposed – providing community based crisis outreach for treatment in the least restrictive environment. In facility, the crisis bed will provide early crisis bed interventions as an alternative to hospitalization, a safe community-based alternative for observation and assessments, preventive crisis stabilization bed for people who are in transition and at high risk to become homeless and hospitalized and as a transitional step down crisis bed from a hospital back to the community.

Our program would be available for outside referrals for clients when the current treatment team becomes part of the crisis stabilization program's treatment team. This is the foundation for success with outside providers – the formation of a multi-provider treatment team. Client characteristics that would be considered upon referral for admission to the program are consenting to participate in treatment, and the multi-provider treatment team believes the crisis stabilization program can successfully treat the proposed client. Our starting point criteria would be based on the collaboration of the treatment team already working with the client, the client's acuity of presenting problems, prior interventions, problem behaviors, symptoms, treatment history, medication adherence, strengths/coping skills, special needs, clinical services and support needed to stabilize the client, and the mix with existing clients in the program. These criteria can be modified by working with the existing crisis bed programs and the recommendations and principles from the Crisis Management Work group that guide clients through the system of care.

We would be committed to work with all stakeholders to standardize the crisis bed program's assessment tools, use the LOCUS upon admission and discharge and have the entrance and exit criteria based on an agreed level of care for crisis beds.

We would be committed to provide evidence-based practices and continuity of programming around psycho education, co-occurring disorders, peer support, DBT, WRAP, medication management and other appropriate interventions as part of the services provided. We would monitor the program's outcomes based on recovery measures and standard LOS for crisis stabilization programs. The multi-purpose program would insure full utilization.

The program will provide an alternative to hospitalization and transitional services in the community for adults, 18 years old and older with an Axis I and Axis II diagnosis. The program will be welcoming to people with co-occurring disorders. Emergency services will be a primary referral group for non-CRT clients along with the primary providers at Behavioral Medicine and other private practitioners in our community. A critical factor in determining the appropriateness for this level of care will be the assessed ability for client safety and the collaboration of the referring provider. Other factors to be considered are the client's acuity of the symptoms and presenting problems, anticipated response to treatment offered by the program, the client's consent to participate in treatment, the program having the capability to treat the client, their co-morbidity amongst their mental, physical and substance use problems and the mix with clients already in the program.

Our program's success in using our crisis bed as an alternative to hospitalization has been based on an existing relationship with the client, early intervention and collaboration between the crisis staff and the treatment team around referral, services in the crisis program, discharge planning and coordination of information and services.
The crisis stabilization program will be open to outside referrals based on the assumption that the referring providers are part of the treatment team and provide good assessments, input around treatment planning, and a clear discharge plan with time frames.

The program will be welcoming to people with co-occurring disorders. It will be critical that all referred people are medically cleared from any co-occurring health problems and people are not undergoing withdrawal from substances and have been detoxed from substances before entering the program. This is to insure there are no current impairments, health and safety risks. All clients will be expected to maintain a safe environment while in the program and be free of drugs and alcohol.
Having the crisis program provide multiple types of crisis services both in the community and in the facility will allow the program to provide as much capacity as possible. The treatment planning process, which will include the referring provider and develop a discharge plan based at admission which is based on the needs that lead to the initial crisis, will facilitate lower LOS since treatment will be focused on critical needs from the start. The crisis program staff will monitor LOS, coordinate capacity with other aspects of the program and work with the state wide care management system.

Outcome data on clients' responses to treatment in the crisis bed program, characteristics of clients discharged to a lower level of care, characteristics of clients discharged to a

higher level of care and clients refused admission, will be incorporated back into admission criteria, services provided, resources and training.

We would work with the state care management team to track those clients that are readmitted to any crisis bed program or inpatient facility within 1 month of discharge. A post crisis bed/readmission follow-up will be conducted by the treating facility to identify where the discharge plan failed resulting in another crisis. The information will be incorporated back into services provided, resources and training in the crisis program.
We will coordinate and modify the entrance and exit criteria and the assessment tools used with the state care management system. Using the LOCUS, we would anticipate a moderate level of harm – level 3 on domain number 1- Risk of Harm. We would be expecting to treat people with destabilizing symptoms and behaviors that are not actively posing danger to the person, other people or property. We anticipate the client will be medically cleared, not undergoing withdrawal from drugs or alcohol and not in need of detox. Using the LOCUS, we would expect a minor level of co-morbidity – level 2 on domain number 3 – Medical, addictive and psychiatric co-morbidity. We would also be expecting people to be engaged and consenting to developing and following a treatment plan that would lead to a quick return back to their community. Using the LOCUS, we would anticipate a positive level of engagement – level 2 on domain number 6 – Engagement. We would anticipate a moderate or equivocal response to treatment and recovery management – level 3 on domain number 5 – Treatment and recovery history. This could complement in-patient referrals where the hospital needs to discharge the person but the person is not quite ready to return to their community living situation. Using the crisis program as an inpatient step down back to the community could provide the necessary services to maximize the gains made in the hospital when the client is still too vulnerable to be independent.

In determining the continued stay and discharge for the client back to the community, safety is the primary factor being determined by the client's acuity/stability. Other factors that will be considered in assessing safety are: is the client at their stable baseline, the client's resources, initial agreed upon time frame to stay in the crisis program, resources available in the crisis program and the referring provider's available resources. In addition to safety, other factors taken into account around continued stay are: the client is actively participating in treatment, making some progress but not at stable baseline, or the client is actively participating in treatment, no progress is yet made but both the client and treatment team believes it is too early to say treatment is unsuccessful.

Discharge criteria to a higher level of care would be considered when the client escalates above the entrance criteria mapped out earlier in this section, the client continues to be unstable and the crisis bed program treatment is unsuccessful, the client continues to be unstable and refuses to participate in treatment, the client's unstable symptoms and/or behaviors become a poor mix with the other clients in the program and/or involuntary procedures are recommended for safety.

The Crisis Beds will be an important component in the CRT and Emergency Services Programs. This new resource will be a critical resource to stabilize individuals in a safe environment and reduce hospitalizations. In addition it will serve as a resource to assist in getting people out of hospitalizations when they are not ready to be on their own but are stable enough for a step down.

Clinical Program.

a) Daily medical oversight

Part of the referring process and prior to admission, the crisis staff will work with the referring provider, emergency services staff and when necessary the Emergency Room at Copley hospital, for medical clearance and determining sobriety from drugs and alcohol. For CRT clients in our program, the treatment team will work with the CARE Team and emergency services and Copley Hospital may not be involved. Once the person is in the crisis program, the crisis staff with nursing and psychiatrist consultation will monitor physical health. When necessary, referrals to Copley hospital's emergency room will be made, as well as coordination with the primary care provider.

b.) Daily access to a psychiatrist

The psychiatrist is a critical person in the treatment team. The crisis stabilization program will have access to a psychiatrist for face–to–face consultation, case review and supervision when needed either on-site or at another facility. Transportation will be provided if the consultation is at another facility.

The role of the psychiatrist includes reviewing current medications and side effects, lab work, reviewing effectiveness of the treatment plan, reviewing client's adherence to the treatment plan, consultation with the primary psychiatrist around medications when the client has another psychiatrist, and consultation with PCP for health issues when needed. The nurse will provide support to psychiatry. It is anticipated that the nurse will play a very active role in the crisis stabilization program.

c) Peer Services and Support

LCMH is currently receiving consultation from VPS and other recovery programs around developing recovery curriculum for the clubhouse. We envision our recovery curriculum to include peer supports around symptom management, problem-solving, advocacy, psycho education of disorders and treatment options and recovery education. We anticipate peer supports to be mobile with an outreach component when appropriate. This could possibly include peer supports going to the crisis beds program. We also anticipate that during the day, clients in the crisis bed could participate in peer activities in the clubhouse. Peer services will be available if peers apply for the positions and are qualified for the job.

d.) Adequate staffing

The staffing pattern is two staff on at all times, 24/7. A total of ten employees will be staffed at this facility. Groups, case management and supportive counseling may also be provided in the crisis program by outside staff. The budget includes funding for an RN and clinically trained staff. One of these positions would be the site manager.
The program will be multi-purposed, including crisis outreach in the community, in-facility observation and assessment, short-term stabilization as an alternative to hospitalization, transitional services for people at risk of being homeless and hospitalized and as a transitional step-down bed from a hospital. All of these functions will require assessment, treatment planning and discharge planning as a collaborative task between the client, referring provider and the crisis bed staff.

e.) Clinical and Therapeutic Assessment Programming

The assessment will begin at referral and will identify life-stressing events, reactions to medications, traumatic events, developmental events, skills, resources and support network available to the client, and past interventions that have been successful and unsuccessful. During this information gathering process, the client's role is critical in identifying their skills, needs, preferences, goals, their support network, their stage of change and their understanding of what is working and not working through using a strength-based assessment. The outcome of the assessment process is to have the client engaged in the treatment process and to have a collaborative understanding amongst the referring provider, the client and the crisis staff of what the identified issues are.

Staff assessment tools that would be considered include the LOCUS, behaviors questionnaire (self harm), reasons questionnaire(self harm), imminent suicide risk assessment worksheet, MIDAS, alcohol use scale, drug use scale, substance abuse treatment scale, and trauma screen.

The treatment phase will continue with the engagement process with the client and build on the client's stated preferences, strengths, support network and stage of change. A large focus of the staff's treatment will be around creating a safe atmosphere that is calming and relaxing so the client can be focused around problem-solving what they and their support network need to do for discharge back to their community. Treatment planning in the crisis bed will be based on the client's selection and personally tailoring the treatment options available. The staff will match the identified treatment options to the client's stage of change and the client's strengths.

The program will offer evidence-based practices and trauma informed treatment. Staff will be trained to treat co-occurring mental health and substance use disorders, DBT skills training for self injury, Risking Connection for trauma informed treatment, WRAP for recovery principles and relapse prevention and crisis planning, Illness Management and Recovery for psycho education around mental health, UCLA social skill modules for medication management, community re-entry, symptom management and substance use.

Other treatments offered will include medication oversight, case management around discharge planning, psychoeducation of mental health, physical health and substance use, family and support network involvement, relaxation training, relapse prevention planning based on triggers and circumstances leading to crisis, symptom management and social skills training on re-entry into the community.

The discharge planning phase begins on admission. The client and the referring provider identify what needs to occur for the client to return back to their community. What are identified becomes the treatment objectives for the specific treatment options in the client's treatment plan while being in the crisis bed. The multi-provider treatment team is critical for successful treatment and discharge from the crisis bed program. There will be an active service coordination piece that helps the client communicate, with their support network and the multi-provider treatment team, their wishes around admission to the crisis bed, treatment planning and discharge planning.

Staffing Patterns

The staffing pattern is two staff on at all times, 24/7. Monday through Friday there would be (3) eight hour shifts. Saturday and Sunday (2) twelve hour shifts. As part of either the first or second shift there will be a Registered nurse and/or Site Manager on staff. This facility will be staffed by ten employees total. The employees working the twelve hour shifts would be utilized to cover vacations, holidays and sick time as well.

III. Proposed Location

The crisis beds would be located in Copley House which is a residential facility owned by Lamoille County Mental Health. There are two; two bedroom apartments located in Copley House We propose to use one of them for crisis beds.

The renovations will be minimal as all we will do is sound proof the apartment. The bedrooms are located at opposite ends of the apartment so confidentiality will not be an issue. We will not need to get a permit for the sound proofing of the apartment. The apartment is ADA compliant and has a sprinkler system in the apartment as is all of Copley House.

Because we will be leasing one of the apartments at Copley House the dates and terms of the lease will be open ended. The lease arrangement will be significantly lower than the purchase option due to the shared overhead cost with Copley House.

IV. System Need, Local Support, Strategic Planning and Outcomes

This proposal is consistent with our Local System of Care plan (LSCP) in 3 areas: 1. Social skills training. The crisis bed program would make available social skills training using the UCLA's social skills modules. Three pertinent modules include community reentry, symptom management and medication management. 2. Continuity of programming with other providers. By developing services that will be available based on the evidence based practices recommendations of the Clinical Advisory Panels, increases continuity of programming with other providers. The crisis bed program will provide services based on the curriculum of UCLA's social skills training, WRAP and Illness Management and Recovery (IMR), Wellness Recovery Action Plans (WRAP), Dialectic Behavior Therapy (DBT) and Integrated Dual Disorder treatment (IDDT). 3. Strength based assessments and treatment plans – In the crisis bed program, the process to develop clinical structures that support self empowerment and collaborative treatment with the crisis staff; we would focus on the informed consent for treatment as the client's commitment. The client's self assessment of their strengths and integrating this into the treatment plan facilitates the client to have meaningful input into their treatment. The client's monitoring of their progress towards their discharge back to the community reinforces the clients' successes during crisis stabilization. The crisis bed program is consistent with the section of our strategic plan identifies increasing opportunities for consumers to be in leadership roles. This would be supported by having peer supports available in the crisis program and also by having the clients in the crisis bed program participate in peer supported recovery activities at 2020.

The crisis bed proposal was discussed with the CRT managers, current crisis team, counselors, psychiatrist, executive director, Human resource director and CFO. The proposal was placed on the Public computer system for all staff to access and to make modifications (in red print). Draft hard copies were shared with staff who requested copies.
One of the items in the Lamoille County Mental Health Strategic Plan is "Secure and Expand Resources and Services." The lack of a Crisis Bed Facility has been something we have recognized as a gap in our continuum of care. In addition during our 2007 review by the Department it was noted that we should better utilizes our residential facilities for crisis stabilization. For our community partners, state and private, the lack of Crisis Stabilization Beds have been recognized as a service gap in the community.

The proposal was reviewed with the Board of Directors at the August 22nd Board meeting and approved. In addition the proposal was reviewed with the CRT Standing Committee. The Standing Committee discussed the following topics:

- What is the population served by the program
- Staff requirements and staffing patterns
- Where will the program be located
- Program' clinical relationship to our current CRT program
- Where do referrals come from
- Safety issues around mixing gender
- Safety issues around entrance criteria, assessments and acuity of clients

- Safety issues with mixing Public Inebriants with mental health clients
- Safety issues around assessing and treating clients where there is no existing treatment relations
- Privacy around the existing floor plan of the current crisis/transitional/respite unit
- Privacy around the degree the existing walls are sound proof
- Privacy of 2 people in the unit together
- Privacy around the staff talking to clients when two clients are in the unity
- Privacy issues around two clients knowing that the other is in the unit
- Screening for Copley ER makes no sense and increases stigma around mental illness
- More handicapped accessible (i.e. Hand bars on doors, etc.)

The conclusion of our CRT Standing Committee was if the program was adequately funded, if privacy could be ensured, if the clients' needs were adequately treated to reduce safety risks and the crisis beds could alleviate some of the pressures within Lamoille County and across the state, then it would be a good idea.
The crisis stabilization bed program will be a CRT standing agenda item. The crisis program staff will update the standing committee of the program's effectiveness within the system of care and possible program changes that need to be made based on the data available. The consumers on the standing committee who are part of the peer support recovery services will provide feedback to the standing committee about recovery services.

- Leveraging resources with existing programs in the network of Designated Agencies and Vermont's hospitals,
- Coordinating with existing facilities and programs, and
- Sharing medical resources

The overall model design is to have some services provided in the crisis Program by existing staff. By providing a high level of coordination of services, case management, community outreach, access to recovery services at 2020, groups and counseling in the crisis program, from our existing programs, we will be shifting resources into the crisis bed program which will in part fund some of these services. Also, by using a multi provider treatment team, some services may be provided by the referring provider (i.e. transportation, case management in the client's community, supportive counseling, treatment planning, assessment, medical information). When needed, Copley Hospital will be accessed as a medical resource. We will coordinate and modify the entrance and exit criteria and the assessment tools used with the state care management system. Using the LOCUS, we would anticipate a moderate level of harm – level 3 on domain number 1- Risk of Harm. We would be expecting to treat people with destabilizing symptoms and behaviors that are not actively posing danger to the person, other people or property. We anticipate the client will be medically cleared, not undergoing withdrawal from drugs or alcohol and not in need of detox. Using the LOCUS, we would expect a minor level of co-morbidity – level 2 on domain number 3 – Medical, addictive and psychiatric co-morbidity. We would also be expecting people to be engaged and consenting to developing and following a treatment plan that would lead to a quick return back to their community. Using the LOCUS, we would anticipate a positive level of engagement – level 2 on domain number 6 – Engagement. We would anticipate a moderate or equivocal response to treatment and

recovery management – level 3 on domain number 5 – Treatment and recovery history. This could complement in-patient referrals where the hospital needs to discharge the person but the person is not quite ready to return to their community living situation. Using the crisis program as an inpatient step down back to the community could provide the necessary services to maximize the gains made in the hospital when the client is still too vulnerable to be independent.

In determining the continued stay and discharge for the client back to the community, safety is the primary factor being determined by the client's acuity/stability. Other factors that will be considered in assessing safety are: is the client at their stable baseline, the client's resources, and initial agreed upon time frame to stay in the crisis program, resources available in the crisis program and the referring provider's available resources. In addition to safety, other factors taken into account around continued stay are: the client is actively participating in treatment, making some progress but not at stable baseline, or the client is actively participating in treatment, no progress is yet made but both the client and treatment team believes it is too early to say treatment is unsuccessful.

Discharge criteria to a higher level of care would be considered when the client escalates above the entrance criteria mapped out earlier in this section, the client continues to be unstable and the crisis bed program treatment is unsuccessful, the client continues to be unstable and refuses to participate in treatment, the client's unstable symptoms and/or behaviors become a poor mix with the other clients in the program and/or involuntary procedures are recommended for safety.

The proposed crisis/hospital diversion bed program is in step with the Health Resource Allocation Plan. As stated previously this will be an alternative to our usual plan of action. With this resource we expect to see a quicker response time to those in Crisis and a reduced need for spending time trying to find a suitable placement. With this facility available we can immediately screen for appropriateness and place the consumer in a safe environment. The issues of having consumers wait hours for a potential placement has been a concern of consumers and staff. In addition consumers will be treated close to home and by staff they are familiar with. In our current situation a consumer's case manager is not available when a placement is far away. With this new resource the case manager will be part of the treatment team working to stabilize the consumer and get them back into their own place of residence. The end result should be an accelerated stabilization period.

a) Reduce inpatient psychiatric admissions to VSH and General Hospitals

The multi purpose design of the program is intended to reduce admissions to inpatient facilities by early community based prevention oriented intervention and system wide service coordination. The community based outreach, observation and assessment beds, services to homeless clients at risk of hospitalization and early stabilization through crisis beds as an alternative to hospitalization are all early interventions that will reduce inpatient admissions. The state wide service coordination is based on having a multi provider treatment team that begins working together at referral to the crisis bed program and work together until discharge.

By having a multi provider treatment team, continuity of treatment planning and programming will augment stabilization at this early stage of intervention

b) Reduce the number of inpatient days at VSH and General Hospitals

The multi purpose design of the program addresses transitional step downs from inpatient services as well as early community based interventions. The transitional step downs are intended to reduce the number of inpatient days.

There are many factors to be considered in measuring the effectiveness of crisis programs. We would support continuity of evaluation of all crisis beds in the state to enhance a system of crisis bed care. Given our support for continuity of evaluation across all crisis programs, we would look at four dimensions – client characteristics, client level of function, client's stage of recovery, stabilization outcomes.

Client characteristics would include:

- Gender
- Age
- Town and county
- Living and work situation
- Support network
- Legal status
- History of hospitalization
- History of crisis bed utilization

Level of functioning would include:

- Diagnosis – Axis I, II, III, IV, V
- Suicidal/homicidal ideation, intent, plans, means, hx at referral
- LOCUS score at referral
- ASAM score
- Alcohol/Drug use scale score

Stage of recovery would include

- Baseline stage of change or recovery around mental health symptoms, non-adapting behaviors, substance use and physical health (prior to decompensation that led to crisis bed referral or inpatient stay)

Stabilization outcomes would include

- Discharge living situation
- Perceived improved in the area of symptoms, non-adapting behaviors, substance use and physical health
- LOCUS at discharge
- Suicidal/homicidal ideation, intent, plans, means, hx at discharge
- Perception of recovery during the stay in the crisis program in the areas of
    - Sense of self-esteem at discharge
    - Reconnecting with parts of self that they were disconnected from at referral
    - Number of strengths they discover they had since referral
    - Effectiveness of peer supported network
    - Confidence they will be stable when once they return back to their community

The clinical oversight and administrative processes to review service utilization for crisis bed stays will be reviewed using the levels of functioning criteria, entrance and exit

criteria, length of stay and type of discharge – back to the community or to a higher level of care. Program effectiveness will be reviewed using the stabilization outcome criteria and comparing the crisis bed program to other crisis bed programs around length of stay, types of discharge and LOCUS scores on referral and discharge.

For community based crisis outreach, utilization will be reviewed by length of time outreach services are provided and number of outreach contacts per day and per week. The effectiveness will be reviewed by number of clients that remain in the community, number of clients that are admitted to the crisis bed program and number of clients that are admitted to inpatient services.

For observation and assessment, utilization will be reviewed by length of time crisis bed services are provided and legal status. The effectiveness will be reviewed by number of clients that remain in the community, number of clients that are admitted to the crisis bed program and number of clients that are admitted to inpatient services

V. Organizational Structure

Lamoille County Mental Health is a 501©3 not for profit corporation designated by the Department of Mental Health to provide services to adults with a severe and persistent mental illness, Children and Families and persons with Developmental Disabilities. We also provide 24 hour 365 days a year Emergency and Crisis Services. The service area is Lamoille County and the bordering towns in Orleans County. As stated previously the Crisis Beds will be a standing agenda item on the CRT Standing meetings. The Board of Directors, which currently 60 % Consumers or Family Members, will be given updates by the Executive Director and solicit input as needed. The Regional Director will be apprised of the utilization by the Executive Director. We will ask for feedback from a consumer once they are discharged from the crisis bed. Lamoille County Mental Health will be the only organization responsible for staffing and operations of the program. We currently have a working relationship with Copley Hospital's Emergency Room and would utilize it as needed to gain medical clearance. As the program becomes operational we will obtain MOUs with local organizations as potential referral sources. The crisis stabilization bed program will be a CRT standing agenda item. The crisis program staff will update the standing committee of the program's effectiveness within the system of care and possible program changes that need to be made based on the data available. The consumers on the standing committee who are part of the peer support recovery services will provide feedback to the standing committee about recovery services.

VI. Projected Costs and Financial Feasibility

The renovations will be minimal as all we will do is sound proof the apartment. The bedrooms are located at opposite ends of the apartment so confidentiality will not be an issue. We will not need to get a permit for the sound proofing of the apartment.
The apartment is ADA compliant and has a sprinkler system in the apartment as is all of Copley House. Because we will be leasing one of the apartments at Copley House the

dates and terms of the lease will be open ended. The lease arrangement will be significantly lower than the purchase option due to the shared overhead cost with Copley House. As stated before this apartment is in an existing residential faculty so the overhead expenses will be shared.

BUDGET: CRISIS BEDS AGENCY: Lamoille County Mental Health

			FY '08	FY '09	FY '10
REVENUE					
	DDMHS GRANT		725549	741487	763755
	Total Revenue		725,549	741487	763755
EXPENSES					
	STAFF			**ANNUAL COST**	
	Site Manager		62,100	63963	65881.89
	Registered Nurse		57,960	59698.8	61489.76
	Clinical Staff	(6) FTE	161,485	166329.55	171319.44
	Case Managers	(2) FTE	64,236	66163.08	68147.97
	Psychiatrist Consultant	10 HRS/WK	95,000	97850	100785.5
	Subtotal of Staff		440,781	454,004	467,625
	Fringe 38%		167496.78	172521.683	177697.333
	Total Staff Cost		608,278	626,526	645,322
	ON-CALL STAFF	**N/A**			
	OPERATING EXPENSES	**Per Year**			
	Rent		18,000	18540	19096.2
	Electricity		1000	1030	1060.9
	Phone		720	741.6	763.85
	Heat		1200	1236	1273.08
	Food		2000	2060	2121.8
	Cleaning/Trash/Laundry		1000	1030	1060.9
	Supplies(Cleaning,Bedding,Bath etc.)		500	515	530.45
	Staff Training		500	515	530.45
	Peer support Group Meetings & Support		500	515	530.45
	Mileage/Transportation		2360	2430.8	2503.72
	Technology Upgrade		5000	0	0
	Total Operating Expenses		32,780	28,613	29,472
	Total Direct Expenses		641,058	655,140	674,794
	Administration Allocation 13.18%		84,491	86,347	88961.57
	Total Expenses		725,549	741,487	763,755